SIOUX FALLS PSYCHOLOGICAL SERVICES
CHILD & ADOLESCENT THERAPY CLINIC
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Child Registration Form for Parents

PARENT QUESTIONNAIRE: Child Health

Child's Name (Last, First):	Date of Birth:	Age:	Sex: M F	Today's Date:
Address: City: State: Zip:				Phone:
Child's Race (circle): White Black Hispanic American Indian Asian Other, specify:				
Child's Doctor:				Doctor's Phone:
Name of person completing this form:	Relationship to child:			Phone:

CHIEF CONCERN:

Who suggested this child be seen for attention, emotional, or behavior problems?

What **concerns** do you have about your child?
a.

b.

c.

How long have you been concerned about this child's behavior?	Please circle ONE: overall, the above concerns are **mild, moderate, or severe**?	Please circle ONE: My concerns are **improving, staying the same, or getting worse**?

Please Describe this child's **strongest areas at home**:
a.

b.

c.

Please describe this child's **weakest areas at home**:
a.

b.

c.

HISTORY: Birth

How much did this child weigh at birth? ___pounds ___ounces
Biological **Father's age** at birth of this child: _____ Number of **pregnancies prior** to this child:_____
Biological **Mother's age** at birth of this child:_____ Number of **miscarriages prior** to this child:_____

Y	**N**	Were there any **problems during the pregnancy**? Specify:
Y	**N**	Were there any **problems during labor / delivery** or **following the birth**? Specify:
Y	**N**	Was the child born by **Cesarean (C-section)**? If yes, circle appropriate response: Planned Emergency
Y	**N**	Was this child born **2 or more weeks before** the 'due date'? If yes, how many weeks early was the child: _____ weeks
Y	**N**	Were any substances or medications used by the mother during the pregnancy? ___Methamphetamine (crystal/ice) ___Beer/wine ___Alcohol ___ Prescription Medication ___Cocaine ___Tobacco ___Marijuana Other:_____
Y	**N**	Were any substances or medications used by the father around the time this child was conceived? ___Methamphetamine ___Beer/wine ___Alcohol ___ Prescription Medication ___Cocaine ___Tobacco ___Marijuana Other:_____

***HISTORY: Developmental Concerns**

Y	**N**	Did this child sit up by 8 months?
Y	**N**	Did this child crawl by 10 months?
Y	**N**	Did this child walk by 15 months?
Y	**N**	Did this child speak two word sentences by 2 years?
Y	**N**	Could strangers understand this child by 3 years?
Y	**N**	Did this child stay dry during the day by 3 ½ years?
Y	**N**	Did this child read simple words by 6 years?

(OFFICE USE ONLY) **Y**= [concern ≥ 6 months: Y N Birth: Y N] * **N**= [Development: Y N]

HISTORY: Behavioral

Y	**N**	Did this child **cry frequently** as an infant?
Y	**N**	Was this child **difficult to calm down** as an infant?
Y	**N**	Did this child **have trouble sleeping** as an infant (e.g., was this child fidgety or overly sleepy)?
Y	**N**	Was this child a **picky or irregular eater** as an infant?
Y	**N**	Did this child have **many temper tantrums** as a toddler?
Y	**N**	Did you have **trouble keeping a babysitter** because of this child's behavior?
Y	**N**	Does this child have **urine accidents**?
Y	**N**	Does this child have **stool / bowel accidents**?
Y	**N**	Does this child often have **nightmares**?
Y	**N**	Has this child ever had **tics or nervous twitches**, such as repeated eye blinking, head jerking, or throat clearing?
Y	**N**	Does this child have any **problems falling asleep**? Specify:
Y	**N**	Does this child have any **problems staying asleep** through the night? Specify:
Y	**N**	Does this child have any **problems getting up** in the morning? Specify:
Y	**N**	Does this child have **frequent stomachaches and headaches**? Specify:
Y	**N**	Does this child have **problems with his/her weight**? Specify:

HISTORY: Health

Y	**N**	Has this child had any **major health problems**? Specify:
Y	**N**	Has this child had frequent **ear infections**?
Y	**N**	Has this child had any **vision / eye or hearing** problems? Specify:
Y	**N**	Has this child ever been **hospitalized** or had **surgery**? Specify:
Y	**N**	Has this child lost **consciousness** or has a **serious head injury**? Specify:
Y	**N**	Has this child had **meningitis** or **encephalitis**? Specify:
Y	**N**	Has this child had **seizures**?
Y	**N**	Has this child had any **difficulties with growth**? Specify:
Y	**N**	Does this child have any **birth defects** or **birthmarks**? Specify:

HISTORY: Family Medical Problems

Is there anyone in this child's family with the following:				If yes, how is this person related to this child?
Y	**N**	**Don't Know**	Neurological Problems	
Y	**N**	**Don't Know**	Learning or reading difficulty	
Y	**N**	**Don't Know**	Depression	
Y	**N**	**Don't Know**	Bipolar Disorder / Manic Depression	
Y	**N**	**Don't Know**	Schizophrenia	
Y	**N**	**Don't Know**	History of physical or sexual abuse	
Y	**N**	**Don't Know**	Alcohol or drug problems	
Y	**N**	**Don't Know**	ADHD / ADD (attention problems)	
Y	**N**	**Don't Know**	Tics or Tourette's disorder	
Y	**N**	**Don't Know**	Trouble with the law	
Y	**N**	**Don't Know**	Medications for nerves or emotional problems	
Y	**N**	**Don't Know**	Thyroid problems	
Y	**N**	**Don't Know**	Exposure to toxic chemicals	
Y	**N**	**Don't Know**	Cardiac problems or sudden death	

(OFFICE USE ONLY) **Behavior:** Y N **Health:** Y N **Family Medical History:** Y N **Baseline: Tics:** Y N **Sleep Problems:** Y N **Stomachache/Headache:** Y N **Weight:** Y N

HISTORY: Child's Past/Current Treatment

Y	**N**	Has this child **ever been diagnosed with ADHD or ADD in the past**? If yes: Year_____ Month _____
Y	**N**	Has this child **ever taken medication for ADHD or ADD in the past**? If yes, do you know the **name**, **dose**, and **time(s) of day** the medication was given?

Name	Dose	Time(s) of Day
Name	Dose	Time(s) of Day

Were you **satisfied** with the medication's effect on the child's symptoms? (circle) Yes No

Y	**N**	Has this child **ever received psychological counseling** for any problems? Specify:
Y	**N**	Has this child ever been on any **long-term medications**? Specify:
Y	**N**	Does this child have any **allergies**? Specify:
Y	**N**	Is this child currently taking **medications**?
Y	**N**	Is this child currently taking any **vitamins or herbal supplements**?

What medication(s), including vitamins or herbal supplements, is this child currently taking?

Name	Dose	Time(s) of day
1.		
2.		
3.		

Are there **any professionals** (such as doctors, psychiatrists, social workers, occupational therapists, speech therapists, physical therapists, or alternative treatments) **currently involved in this child's care?** Please **list them and their role** in your child's care:

HISTORY: Social

Y	**N**	Have there been any **major changes or stresses** in this child's life (e.g., marital problems, a move, change of school, birth of a brother or sister, a death of a pet)? If yes, please specify and include how old the child was at the time: Is this stress still occurring? (circle) Yes No
Y	**N**	Has there been a **serious illness or death** in a parent or close family member of this child? If yes, please specify and include how old the child was at the time:
Y	**N**	Has this child **experienced or seen any traumatic events** (e.g., domestic violence, physical or sexual abuse) that you would like to discuss with your therapist? If yes, please specify and include how old the child was at the time: Is this trauma still occurring? (circle) Yes No
Y	**N**	Are there any **major changes or stresses** expected in the future? If yes, please specify:

(OFFICE USE ONLY) **Adhd Dx:** Y N **Adhd Tx:** Y N **Medications:** Y N **Professionals:** Y N **Social:** Y N

HISTORY: Child's Living Arrangement

1. **This child is currently living with** (please check one)
- ☐ Biological mother **and** biological father
- ☐ Biological mother
- ☐ Biological father
- ☐ Relative (specify relationship):
- ☐ Adoptive patent(s), relative
  Does the child know that he/she is adopted? (circle) Y N
- ☐ Adoptive patent(s), non-relative
  Does the child know that he/she is adopted? (circle) Y N
- ☐ Foster Parent(s)
  How long has this child been in foster care? Year_____ Month_____
  How long has this child been living in your household? Year_____ Month_____
- ☐ Other (specify):

2. The **biological** parents of this child are currently
- ☐ Married to each other Year_____ Month_____
- ☐ Divorced from each other Year_____ Month_____
- ☐ Separated from each other Year_____ Month_____
- ☐ Never married to each other
- ☐ Other (please specify):
- ☐ Non applicable (please specify):
- ☐ Don't know

3. How would you describe the **current relationship** between this child's **biological parents**:
- ☐ Friendly/Amicable
- ☐ Unfriendly/Conflict ridden
- ☐ No relationship
- ☐ Not Applicable (please specify):
- ☐ Don't Know

Y	**N**	4. Are there any **immediate family members** who do not live with this child (biological mother, biological father, or siblings? If yes, please specify relationship to child:
Y	**N**	5. Is there anything unusual about this child's **living arrangement** that you would like to discuss with the child's therapist? If yes, please specify:
Y	**N**	6. Are the parent(s)/guardian(s) of this child **working outside of the home**?
Y	**N**	7. Do you have family or social **support locally**?

8. Please list all people who are currently living in this child's household.

Name	Relationship to Child	Age	Name	Relationship to Child	Age

HISTORY: Military Family

Y	**N**	1. Are you or another parent/guardian of your child currently in the Military?
Y	**N**	2. What Branch: Navy Marine Air Force Army Other(specify):
Y	**N**	3. Are any of this child's parent(s)/guardian(s) Active Duty Military? If yes, who (circle): Mother Father Both Other:
Y	**N**	4. Are they deployed or deployable?
		5. When did you PCS/Move to this Location? Date:
		6. When are you due to PCS/Move? Date:
Y	**N**	7. Do you live in military housing?
Y	**N**	8. Is this child or other members of this family in the Exceptional Family Member Program?

(OFFICE USE ONLY) Living Arrangement: Y N

PARENT QUESTIONNAIRE: Child Behavior

Child's Name:				
Check the box that best describes your child's behavior over the past 6 months. *If your child is currently taking medication, please rate your child's behavior NOT on medication.*	Never Rarely 0	Occa-sionally 1	Often 2	Very Often 3
1. **Fails to give close attention** to detail or **makes careless mistakes** (e.g., homework).				
2. Has **difficulty attending** to what needs to be done.				
3. **Does not seem to listen** when spoken to directly.				
4. **Does not follow through** when given directions.				
5. Has **difficulties organizing** tasks and activities.				
6. **Avoids, dislikes,** or does not want to start new tasks.				
7. **Loses things** necessary for tasks or activities (school assignments, pencils, books).				
8. Is **easily distracted** by noises or other things.				
9. Is **forgetful** in daily activities.				
10. **Fidgets** with hands or feet or squirms in seat.				
11. **Leaves seat** when he/she is supposed to stay in seat.				
12. **Runs about or climbs** too much when he/she is supposed to stay seated.				
13. Has **difficulty playing** or starting quiet games.				
14. Is "**on the go**" or acts as if "driven by a motor".				
15. **Talks too much**.				
16. **Blurts out answers** before questions have been completed.				
17. Has **difficulty waiting his/her turn**.				
18. **Interrupts** or bothers others when they are talking or playing games.				
19. **Argues** with adults.				
20. **Loses temper**.				
21. Actively **disobeys or refuses** to follow adult's request or rules.				
22. **Bothers people** on purpose.				
23. **Blames others** for his or her mistakes or misbehaviors.				
24. Is **touchy or easily annoyed** by others.				
25. Is **angry or bitter**.				
26. Is **hateful** and wants to get even.				
27. **Bullies**, threatens, or scares others.				
28. **Starts physical fights**.				
29. **Lies** to get out of trouble or to avoid jobs (i.e. "cons" others).				
30. **Skips school** without permission.				
31. Is **physically unkind** to people.				
32. Has **stolen things** that have value.				
33. **Destroys others' property** on purpose.				

(OFFICE USE ONLY) **1—9 :** ____ / 9 Inattentive: ☐ ≥ 6 / 9 DuPaul: **10—18:** ____ / 9 Hyperactive ☐ ≥ 6 / 9 DuPaul: **19—26:** ____ / 8 Oppositional Defiant Disorder ☐ ≥ 4 / 8

Child's Name:				
Check the box that best describes your child's behavior over the past 6 months. *If your child is currently taking medication, please rate your child's behavior NOT on medication.*	Never Rarely 0	Occa-sionally 1	Often 2	Very Often 3
34. Is physically **mean to animals**.				
35. Has **set fires** on purpose to cause damage.				
36. Has **broken into** someone else's home, business, or car.				
37. Has **stayed out all night** without permission or **run away** from home overnight.				
38. Has **used a weapon** that can cause serious physical harm (e.g. bat, broken bottle, brick).				
39. Is **fearful, anxious, or worried**.				
40. Is **afraid to try new things** for fear of making mistakes.				
41. Feels **useless or inferior**.				
42. **Blames self** for problems, feels at fault.				
43. Feels **lonely, unwanted, or unloved**; complains that "no one loves me".				
44. Is **sad or unhappy**.				
45. Feels **different and easily embarrassed**.				
46. Is **overly concerned about health/body**.				
47. Has problems getting along with **you**.				
48. Has problems getting along with **others his/her own age**.				
49. Has problems getting along with **his/her own siblings**.				
50. Has problems in **group activities** such as games or team play.				
51. **Decreased interest or pleasure in all**, or almost all, activities of the day.				
52. Has **said things like "I wish I were dead"** or has tried to hurt self.				
53. **Recurrent excessive distress** when separation from home or caretakers.				
54. Has **distinct periods of unusually irritable or unusually cheerful mood** (different from normal).				
55. Has **prolonged temper tantrums** (greater than 20-30 minutes).				
56. **Hears voices** others do not hear.				
57. Has **compulsions** (e.g. child seems driven to wash hands, count, erase until holes appear.)				
58. Has **obsessions** (e.g. persistent or repetitive distressing thoughts: germs, doors left unlocked).				
59. Has **recurrent recollections or dreams** of a traumatic event.				
60. Seems to **avoid or have phobias** of specific people, animals, things, or situations.				
61. Seems **unaware of others' existence**, is **uninterested in interacting with others**.				
62. Has **odd, eccentric or unusual preoccupations** (e.g. clothing items, toys, neatness).				
63. Appears **uninterested in activities** children his or her age usually like or participate in.				
64. Has experimented with or abused **drugs or alcohol**.				

(OFFICE USE ONLY) **27—38 :** ____ / 12 Conduct Disorder: ☐ ≥ 3 / 12 **39—46:** ____ / 8 Anxiety/Depression ☐ ≥ 3 / 8 **47—50:** ____ / 4 Social Functioning ☐ ≥ 1 / 4 **51—64:** ____ / 14 MH Concerns

PARENT QUESTIONNAIRE: School History

Child's Name:	Length of time at present school:	Current Grade:
Name of School:	School District:	
Teacher (main):	Principal:	School Phone:

1. Please describe this child's **strongest** areas in his/her **schoolwork**:	2. Please describe this child's **weakest** areas in his/her **schoolwork**:
a. b. c.	a. b. c.

HISTORY: School Intervention

Y	**N**	1. Has this child been in an **Early Intervention program or Special Day Care/Preschool**?
Y	**N**	2. Has this child had **speech, occupational or physical therapy**?
Y	**N**	3. Has this child ever **attended summer school**? If Yes, specify subject(s)/grade(s):
Y	**N**	4. Has the school ever **discussed this child attending summer school** with you? Specify:
Y	**N**	5. Has this child ever **repeated a grade**? If Yes, specify subject(s)/ grade(s):
Y	**N**	6. Has the school ever **discussed this child repeating a grade** with you? Specify:
Y	**N**	7. Is there a possibility that **current grade or subjects will need repeating**? Specify:
Y	**N**	8. Has this child ever received any **special education services** (like a 504 Plan or IEP)? Specify:
Y	**N**	9. Is this child **currently receiving any special education services** (like a 504 Plan or IEP)? Specify:
Y	**N**	10. Have any **disciplinary actions** been taken (detentions, suspension, or expulsion)? Specify:
Y	**N**	11. Does this child need any **special medical assistance**? Specify:

HISTORY: School Problems For each of the following grades this child has completed, were any **problems reported**? If Yes, please **describe** the teacher or parent concerns in the space provided.

			Academics	**Behavior**
Y	**N**	1. Preschool		
Y	**N**	2. Kindergarten and First Grade		
Y	**N**	3. Second and Third Grade		
Y	**N**	4. Fourth and Fifth Grade		
Y	**N**	5. Sixth through Eighth Grade		
Y	**N**	6. High School		

CURRENT: School Performance Please circle the appropriate number.

	Above Average		**Average**		**Problematic**		**Above Average**		**Average**		**Problematic**
1. Classroom Assignment Completion	1	2	3	4	5	8. Science	1	2	3	4	5
2. Homework Completion	1	2	3	4	5	9. Written Expression	1	2	3	4	5
3. Getting Homework to and from school	1	2	3	4	5	10. Handwriting	1	2	3	4	5
4. Organizational Skills	1	2	3	4	5	11. Social Studies/History	1	2	3	4	5
5. Reading	1	2	3	4	5	12. Art	1	2	3	4	5
6. Spelling	1	2	3	4	5	13. Other:	1	2	3	4	5
7. Mathematics	1	2	3	4	5						

(OFFICE USE ONLY)	School Intervention: Y N	Academic Social Problems: Y N	Behavior School Problems: Y N	School Performance: Y N

PARENT QUESTIONNAIRE: Child Summary

Child's Name:

HISTORY: Summary

1. Please **summarize** your **child's <u>OVERALL</u> functioning** (i.e., emotionally, behaviorally, socially, academically, etc.) by choosing **ONE** number below. Compare your child's functioning in 3 settings—home, school, and with peers, to "average children" his/her age that you are familiar with from your experience. **Please circle only one number**.

1	**Excellent** functioning / No impairment in settings
2	**Good** functioning / Rarely shows impairment in settings
3	**Mild** difficulty in functioning / Sometimes shows impairment in settings
4	**Moderate** difficulty in functioning / Usually shows impairment in settings
5	**Severe** difficulties in functioning / Most of the time shows impairment in settings
6	**Needs considerable supervision** in **all** settings to prevent from hurting self or others
7	**Needs 24-hour <u>professional</u> care and supervision** due to severe behavior or gross impairment(s)

Do you have any other comments that you think would be helpful?

(OFFICE USE ONLY)	Impairment: ☐ ≥ 4 Y N

